PEEHIP

Public Education Employees' Health Insurance Plan

Open Enrollment Packet 2008-2009

Deadline August 31, 2008

Effective October 1, 2008

PEEHIP

Public Education Employees' Health Insurance Plan (PEEHIP)

Office Location
135 South Union Street
Montgomery, AL 36104-0001
www.rsa-al.gov

Mailing Address
P. O. Box 302150
Montgomery, AL 36130-2150

Phone Numbers
334-832-4140
800-214-2158
Fax: 334-240-3230

Student Verification
334-832-4140, Extension 1460
800-214-2158, Extension 1460

Flexible Spending Accounts
334-832-4140
800-214-2158

Wellness Program (Offered by PEEHIP and administered by the Alabama Department of Public Health)
RSA Tower, Suite 900
P.O. Box 303170
Montgomery, AL 36130-3017
334-206-5300 or 800-252-1818
www.adph.org

Tobacco Cessation Quitline
800-QUIT-NOW
800-784-8669

Weight Watchers
334-206-5300
800-252-1818

Blue Cross Blue Shield of Alabama

Administrator of Hospital/Medical, Flexible Spending Accounts, Supplemental, & CHIP Plans

450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298
www.bcbsal.org/peehip1/

Customer Service
800-327-3994

Preadmission Certification
800-354-7412

Flexible Benefits
800-213-7930

Rapid Response to order ID cards, directories and claim forms
800-248-5123

Fraud Hot Line
800-824-4391

Express Scripts, Inc.

P.O. Box 66773
St. Louis, MO 63166-6773
www.express-scripts.com

Curascript Specialty Pharmacy
866-848-9870 Fax: 888-773-7386
www.curascript.com

Customer Service *(Available 24 hours/day)*
866-243-2125

Prior Authorization for Step Therapy
800-347-5841 Fax: 800-357-9577

Pharmacy Help Desk *(Available 24 hours/day to assist pharmacists with PEEHIP questions)*
800-235-4357

VIVA Health Plan HMO

1222 14th Avenue South
Birmingham, AL 35205
205-558-7474
800-294-7780
www.vivahealth.com

Southland National Insurance Corporation

Administrator of Cancer, Dental, Indemnity, & Vision Optional Plans
1812 University Blvd.
P.O. Box 1250
Tuscaloosa, AL 35403
800-476-0677
www.southlandnationalpeehip.com

Open Enrollment Information

The Public Education Employees' Health Insurance Plan (PEEHIP) welcomes you to this year's Open Enrollment Packet. This packet is an important part of our commitment to provide PEEHIP members with valuable information about their health care benefits. **Please read** this packet carefully and keep it with your other PEEHIP and retirement materials.

- All of the open enrollment forms are in the back of this packet.
- A self-addressed envelope is provided for your convenience.
- The Open Enrollment period is from **July 1, 2008**, to **August 31, 2008**, for an effective date of **October 1, 2008**. Members have until **September 10, 2008**, to make Open Enrollment changes through the **Member Online Services** system accessible at www.rsa-al.gov.
- Members have until September 30, 2008, to enroll in the PEEHIP Flexible Spending Accounts.
- To continue current insurance coverage, **do not** complete the Health Insurance and Optional Enrollment Application or Health Insurance and Optional Status Change form. You will automatically remain enrolled in your present insurance coverage and premiums will continue to be deducted from your check.
- You **are required** to re-enroll in the PEEHIP Flexible Spending Accounts, Federal Poverty Level Premium Discount, and the PEEHIP Children's Health Insurance Program (CHIP). These three programs do not automatically renew each year without a new application. To re-enroll in any of these three programs, you will need to complete the appropriate application in the back of this packet or re-enroll by using the Member Online Services at www.rsa-al.gov.
- You are not required to complete the Tobacco Certification form every year unless you or your spouse have a change in your tobacco status. If your or your spouse's tobacco status has changed, please complete the appropriate boxes on the Health Insurance and Optional Status Change form and mail the form to the PEEHIP office or update your tobacco status through the Member Online Services at www.rsa-al.gov.
- Waiting periods or pre-existing conditions will be waived for all new coverages effective October 1, 2008.

All open enrollment forms and written requests must be postmarked no later than August 31, 2008, for the PEEHIP office to accept the written request. Members have until September 10, 2008, to make open enrollment changes online through the Member Online Services system. Visit the new and improved PEEHIP Web site at **www.rsa-al.gov** and select **Member Online Services**. After September 10, 2008, online open enrollment changes will not be accepted.

New PEEHIP Policies, Benefit and Premium Changes Effective October 1, 2008

Prescription Drug Changes

◊ *Expansion of the Step Therapy Program*

The PEEHIP prescription drug program includes Step Therapy for certain medications. Step Therapy is organized in a series of "steps" with your doctor approving your medications every step of the way. The first step drugs are usually the therapeutically equivalent generic drugs, and the second step drugs are generally the brand name drugs. The Step Therapy program was implemented to keep PEEHIP sound and premiums and copayments at a reasonable and affordable level.

The PEEHIP Board recently approved eight new drug classes to be included in the Step Therapy drug program. The expansion of the PEEHIP Step Therapy program will apply to new prescriptions written on or after October 1, 2008. Anyone who is currently on the brand name medications will be grandfathered in and will not be subject to the step therapy process if there has not been more than a 130-day lapse in the purchase dates. The drug classes and names of the medications that are part of the PEEHIP Step Therapy program can be found on the RSA Web site.

The PEEHIP Board also approved the extension of the look back period of the first step drugs from 130

days to twelve months for the Leukotriene category of prescription drugs which are used to treat allergies, and the Non-Sedating Antihistamines, Decongestants, and Nasal Steroids allergy medications. In other words, if a covered member has used a drug in any of the three categories of drugs in the last 12 months, the covered member will not be required to use the first step medication.

◊ *Quantity Level Limit (QLL)*
In addition to the Step Therapy program, the PEEHIP Board extended the quantity level limit program to the following medications: **Enbrel, Humira. Actiq, Fentora, Oxycontin, Migranal, Imitrex,** and **Zomig**. The quantity level limit feature in the prescription drug plan is necessary to ensure the prescription drugs are prescribed in a safe manner to prevent our members from obtaining a quantity that does not meet the FDA guidelines and to prevent abuse and misuse of these prescription drugs. **Actiq, Fentora,** and **Oxycontin** are Schedule II narcotics and are prescribed for patients with chronic illnesses such as cancer to prevent breakthrough cancer pain. **Enbrel** and **Humira** are prescribed to treat inflammatory disorders. **Imitrex, Migranal,** and **Zomig** are prescribed to treat migraine headaches.

◊ *Prior Authorization Requirements*
Effective October 1, 2008, new prescriptions for the medications **Byetta, Symlin, Fentora,** and **Seroquel** will require a prior authorization from the physician before the medications will be covered by PEEHIP. This prior authorization process is necessary to prevent members from using the medications for non-FDA approved indications. These drugs will only be covered for the FDA-approved medical conditions and will not be approved for such off label use for weight loss, athletic performance enhancement as well as for pain management, insomnia, and headaches.

Premium Changes
The PEEHIP Board voted to keep the out-of-pocket premium rates for active and retired members at the same level as the premium rates for the 2007-2008 plan year. Members who retired on or after October 1, 2005, may experience rate adjustments because their premiums are subject to the sliding scale where the premiums are based on their years of service and the cost of the insurance program. Also, non-Medicare members and dependents may experience a modest increase in premium rates effective January 1, 2009.

Tobacco Surcharge
The monthly tobacco premium for a covered member or spouse will increase to $23.00 per month on October 1, 2008. The PEEHIP Board approved a tobacco surcharge policy that will raise the tobacco premium each year by the same percentage increase as the medical inflation rate. The tobacco surcharge only applies to the hospital medical plan and HMO plan, not the optional plans.

Viva Health Changes
The Viva Health Plan HMO will continue as an option for active employees and non-Medicare eligible retirees. The Viva HMO option will **not be** available to retired members who are Medicare eligible or to retired members who have Medicare eligible dependents. Retired members or dependents who are currently enrolled in the Viva HMO will be allowed to enroll in the PEEHIP hospital medical plan when they become Medicare-eligible so they will continue to have a Medicare supplemental plan.

Worksite Wellness Program
PEEHIP works in cooperation with the Alabama Department of Public Health (ADPH) to offer a statewide Worksite Wellness Program for PEEHIP covered participants. Members and dependents covered by the PEEHIP hospital medical plan, HMO or optional plans will continue to receive free health screenings by the Public Health Department nurses at different sites during the year. The Worksite Wellness Program is intended to assist employees and their families in making voluntary behavior changes which reduce their health risk and enhance their individual productivity. In addition to the free health screenings, PEEHIP will continue to offer the Weight Watchers Program which will allow eligible members to participate in a 15-week Weight Watchers Program for only $85. Members who have a body mass index of 25 or more will be eligible to participate in the PEEHIP Weight Watchers program. You can calculate your body mass index on any of the following Web sites: www.nhlbisupport.com/bmi/, www.caloriecontrol.org/bmi.html, or www.consumer.gov/weightloss/bmi.htm.

The member's cost is $85 for a 15-week program with PEEHIP paying the remaining $85. PEEHIP will pay its $85 share provided the member attends at least 12 of the 15 sessions. Members may be required to pay a higher amount if they do not complete the entire Weight Watchers program. Additional information can be obtained on the Public Health Department Web site at www.adph.org/worksitewellness or by calling 334-206-5300 or 800-252-1818 and asking for the Wellness Division.

It's Fast, Free, Secure and Accurate!
PEEHIP's New & Improved Member Online Services System!

PEEHIP has a new and improved Member Online Services system that is fast, free, secure and accurate! Click on the **Member Online Services** link from the RSA Web site at www.rsa-al.gov to access the online system. All you need is a User ID and Password to begin using the Member Online Services system. If you don't already have these, registering for an account is easy! The link above will guide you through the necessary steps to set up your account to obtain a User ID and Password. The new Member Online Services system will be available through the **entire** Open Enrollment period of July 1, 2008 through September 10, 2008. The online system is also available outside of the Open Enrollment period to new employees and members that have Qualifying Life Events to enroll in or make changes to their coverage.

This new online system allows PEEHIP members to easily and efficiently change and/or enroll in health insurance coverage and flex accounts, and it even **calculates your PEEHIP premium** based upon the coverages you elected so that you will know what your premium will be prior to electronically submitting your enrollment or change form! Members can also quickly update various other PEEHIP forms and information online without having to go through the entire enrollment application or status change form process. Available also is the ability to view current health insurance coverage and view and update personal contact information online. A **confirmation page with a confirmation number** along with a date and time stamp are given online to the member at the completion of successfully enrolling, changing and/or updating their health insurance, contact information, and/or other forms.

No more paper forms, envelopes, stamps or last minute runs to the post office when you use the RSA's Member Online Services system! RSA and PEEHIP continually strive to improve the services we provide to our members. Use the electronic Member Online Services system and we all benefit in terms of greater efficiency and effectiveness as well as savings in time and costs!

PEEHIP Members Can Do the Following Online:

- View Current Coverages
- View and/or Update your Contact Information
- Enroll, Change or Cancel your Hospital Medical Plan
- Enroll, Change or Cancel your Optional Coverage Plans (Cancer, Dental, Indemnity & Vision)
- Add, Update or Cancel your Other (non-PEEHIP) Group Insurance Coverage Information
- Enroll or Re-enroll in Flexible Spending Accounts
- Add or Update your Medicare Information
- Add or Update Retiree Employer Information
- Combine or Uncombine Allocations with your Spouse
- Update your Student Dependent Status
- Update your and/or your Spouse's Tobacco Usage Status
- Add Dependent(s) to Coverage
- Cancel Dependent(s) from Coverage

Premium Rates
PEEHIP Premium Rates 2008 – 2009 Plan Year

The following monthly premiums are effective October 1, 2008 - September 30, 2009. **These premium rates do not include the $23.00 monthly tobacco surcharge.**

Active Members

PEEHIP Hospital Medical or VIVA Health Plan

Coverage		Allocation - Cost to State	Monthly Out-of-Pocket Cost
Single	$754.00	$752.00	$ 2.00
Family	$886.00	$752.00	$134.00

COBRA and Leave of Absence Rates

Single	$365.00
Family	$868.00

Retired Members

The premiums listed in the charts below show the retiree's out-of-pocket cost after subtracting the retiree allocation. These rates apply only to members who retired prior to October 1, 2005, or members who retired on or after October 1, 2005, with 25 years of service. All members who retired on or after October 1, 2005, are subject to the Retiree Sliding Scale premium based on years of service. These retirees may experience a rate adjustment effective October 1, 2008. The sliding scale premium rates can be found on the PEEHIP Web site at **www.rsa-al.gov**. **Also, non-Medicare members and dependents may experience a modest increase in premium rates effective January 1, 2009.**

Type of Contract	*Retiree Monthly Out-of-Pocket Premium	Cost to State on Behalf of the Retiree
Individual Coverage/ Non-Medicare Eligible Retired Member	$ 97.54	$487.46
Family Coverage/Non-Medicare Eligible Retired Member and Non-Medicare Eligible Dependent(s)	$284.94	$813.06
Family Coverage/Non-Medicare Eligible Retired Member and Dependent Medicare Eligible	$188.54	$698.46
Individual Coverage/ Medicare Eligible Retired Member	$ 1.14	$288.86
Family Coverage/Medicare Eligible Retired Member and Non-Medicare Eligible Dependent(s)	$188.54	$614.46
Family Coverage/Medicare Eligible Retired Member and Dependent Medicare Eligible	$ 92.14	$499.86

Out-of-Pocket if Retiree and Retired Spouse Combine Allocations	*Retiree Monthly Out-of-Pocket Premium	Cost to State on Behalf of the Retiree
Retiree <65 Dependent <65	$164.94	$933.06
Retiree <65 Dependent >65	$ 68.54	$818.46
Retiree >65 Dependent <65	$ 68.54	$734.46
Retiree >65 Dependent >65	$ 0.00	$592.00

**This rate applies to the PEEHIP Hospital Medical or the Viva HMO Plan and is the monthly amount that will be deducted from a retiree's check. The VIVA HMO Plan is not available to retired members who are Medicare eligible or dependents who are Medicare eligible.*

Surviving Dependent Monthly Premiums for the 2008-2009 Plan Year

Type of Contract	Monthly Premium for PEEHIP Hospital Medical or the VIVA Health Plan
Individual Coverage/Non-Medicare-eligible Survivor	$585
Family Coverage/Non-Medicare-eligible Survivor and Non-Medicare-eligible Dependents	$717
Family Coverage/Non-Medicare-eligible Survivor and Only Dependent Medicare-eligible	$676
Individual Coverage/Medicare-eligible Survivor	$290
Family Coverage/Medicare-eligible Survivor and Non-Medicare-eligible Dependent(s)	$422
Family Coverage/Medicare-eligible Survivor and Only Dependent Medicare-eligible	$381
Optional (Each)	$ 38

If a husband or wife retired on or after October 1, 2005, and they decide to combine their insurance allocations and carry family coverage, the out-of-pocket costs must be calculated by a PEEHIP or TRS counselor because of the infinite combinations of rates. It is usually more cost effective for a husband and wife who are both PEEHIP eligible to combine their allocations and carry family coverage instead of carrying two individual policies.

The state allocation can be used to purchase the PEEHIP Supplemental Plan or **two** optional plans at no cost to the retiree if the retiree is not using the allocation for one of the hospital medical plans or combining allocations. Additional optional plans can be purchased for $38.00 per month per plan. Full-time active members can use their allocation to purchase the PEEHIP Supplemental Plan or **four** Optional Plans in lieu of the hospital medical plan.

	Optional Coverage:	**Active and Retired Members**
Cancer	$38.00/month	Individual or Family Coverage
Indemnity	$38.00/month	Individual or Family Coverage
Dental	$38.00/month	Individual or Family Coverage
Vision	$38.00/month	Individual or Family Coverage

If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, the PEEHIP office must receive a copy of the Medicare card before the premiums can be reduced. However, PEEHIP will pay secondary to Medicare once our office becomes aware of your Medicare eligibility regardless of whether our office has received your Medicare card. Medicare eligible members and dependents should have Medicare Part A and Part B to have adequate coverage with PEEHIP.

Medicare rules require a Medicare-eligible, active PEEHIP member who is covered on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer on the active PEEHIP member. Therefore, the active Medicare-eligible member will need Medicare Part A and Part B coverage.

If the active member does not want Medicare as his or her primary payer and does not want to enroll in Medicare Part B until retirement, he or she will have to be insured on their own PEEHIP **active** contract and will not be able to combine allocations with the retired PEEHIP-eligible spouse. When the active Medicare-eligible member retires, he or she will need to enroll in Medicare Part B. The effective date of Medicare Part B needs to be the date of retirement to avoid a lapse in coverage. Active members must wait and enroll during Open Enrollment.

PEEHIP HOSPITAL MEDICAL COVERAGE (Administered by Blue Cross)

(Coverage for Active Members and Non-Medicare Eligible Retirees)

Hospital Benefits *(Administered by Blue Cross)*

- Inpatient Hospitalization: Services are covered in full for 365 days without a dollar limit.
- Deductible: $100 for each admission. You are also responsible for the difference between private and semi-private accommodations and other non-medical items, such as TV, phone, etc.
- Preadmission Certification (PAC): All admissions will be subject to Preadmission Certification by completing a Blue Cross Blue Shield of Alabama Preadmission Certification form. Emergency admissions must be certified by the first business day

following the admission by calling 800-354-7412.

- Inpatient Rehabilitation: Coverage in a rehabilitation facility limited to one admission per illness or accident; one per lifetime with a 60-day maximum. Precertification is required.
- Outpatient Hospital Charges: $75 facility copay for outpatient surgery and $25 facility copay for medical emergencies and hemodialysis. There is no copay required for accident related services rendered within 72 hours after the accident.

Major Medical Benefits *(Administered by Blue Cross)*

- Deductible: $100 deductible per person per calendar year; maximum of 3 deductibles per family per year.
- Maximum: $1,000,000 lifetime maximum for each covered member.
- Coinsurance: After you pay the $100 deductible, the plan pays 80% of the Usual Customary Rates (UCR) of covered expenses for the first $2,000 and 100% UCR thereafter.
- Covered Services: Physician services for medical and surgical care when you do not use a PMD physician; laboratory and X-rays, (outpatient MRI's must be precertified); ambulance service; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; podiatrist services; physical therapy; allergy testing and treatments; semi-private room and other hospital care after basic hospital benefits expire.

Preferred Medical Doctor (PMD)

- $3 Copay Per Test: Outpatient diagnostic lab and pathology (including pap smears).
- $20 Copay Per Visit: Doctor's office visits and consultations; one routine preventive visit each year for adults age 19 and over.

PPO Blue Card Benefits *(Out-of-State Providers)*

- The Blue Card PPO program offers "PMD-like" benefits when members access out-of-state providers if the physician or hospital is a participant in the local Blue Cross PPO program in that state. This program allows members to receive PMD benefits such as well baby care, routine physicals and routine mammograms when accessing out-of-state PPO providers.

Non-Participating Hospitals and Outpatient Facilities

- Currently there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are a Blue Cross and Blue Shield participating provider. With your health plan benefits, you have the freedom to choose your health care provider.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don't have to worry about extra out-of-pocket expenses.

Out-of-Country Coverage

- If you receive medical treatment outside of the United States and the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross of Alabama.

Pharmacy Program *(Administered by Express Scripts)*

- Participating Pharmacy: When you choose a Participating Pharmacy you pay the following:
  - ◊ $5 for any covered generic prescription drug
  - ◊ $30 for any covered preferred brand drug (The preferred brand drug list can be found on the PEEHIP Web site at www.rsa-al.gov.)
  - ◊ $50 for any covered non-preferred brand drug
- Participating pharmacies will file all claims for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP Express Scripts prescription drug plan.
- Members and covered dependents must use Curascripts for all specialty medications.
- The PEEHIP prescription drug plan includes Step Therapy and prior authorization for certain medications.

Non-Participating Pharmacy

- There are no benefits if you use a non-participating pharmacy in Alabama.
- Coverage outside Alabama: You will file the claim and be reimbursed at the Participating Pharmacy rate less the appropriate copay.

Excluded Services

- Coverage is not provided for nursing home costs, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids and experimental procedures.

Wellness Program *(Administered by the Alabama Department of Public Health)*

Members and dependents covered by the PEEHIP Hospital Medical Plan, HMO or optional plans can receive free health screening by the Public Health Department nurses at different sites during the year. The health screening tests include blood pressure, glucose, and an HDL/LDL cholesterol screening as well as osteoporosis screenings for high risk members.

The PEEHIP Wellness program also includes a smoking cessation toll-free Quitline (800-784-8669) which is available 24-hours a day providing live counseling from 8:00 a.m. until 8:00 p.m., Monday through Friday. The Wellness program also includes a Weight Watchers benefit for high risk members who have a body mass index of 25 or more. The member's cost is $85.00 for a 15-week program with PEEHIP paying the remaining $85.00. Members must attend at least 12 of the 15 sessions to receive full reimbursement by PEEHIP.

PEEHIP MEDICARE PLUS (Administered by Blue Cross)

(Coverage for Medicare Eligible Retirees)

This plan is a supplement to hospital and medical benefits provided under Medicare Parts A and B and is available to Medicare eligible retirees. This coverage is similar in nature to C-Plus and other Medicare supplemental insurance plans. It provides hospital and non-hospital benefits as outlined below. This plan does not provide benefits for custodial care such as help in walking, eating, bathing and dressing. Members must have Medicare Part A and Part B, and Medicare must be your primary payer for claims. Most Medicare eligible members and dependents should not enroll in the new Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage.

PEEHIP Hospital Benefits *(Administered by Blue Cross)*

Benefit	Medicare Pays	PEEHIP Pays	YOU Pay
Inpatient Hospital Charges	All but the Part A deductible per admission. All but applicable coinsurance after 60 days.	All but $100 per admission. Applicable coinsurance after 60 days.	A $100 deductible and any personal charges (such as private room, telephone, TV, etc.).

PEEHIP Non-Hospital Benefits

Benefit	Medicare Pays	PEEHIP Pays	YOU Pay
Outpatient Hospital Charges	80% of Medicare's approved amount after the Medicare Part B deductible.	20% of Medicare's approved amount after the member meets Medicare Part B deductible and the $20 copay for physician visit.	The Part B deductible, a copay up to $20 for physician visits, any charges not covered by Medicare or PEEHIP, and charges above the Medicare allowable amount when using unassigned providers.

Pharmacy Program *(Administered by Express Scripts)*

- Participating Pharmacy: When using a Participating Pharmacy you pay the following:
  - ◊ $5 for any covered generic prescription drug
  - ◊ $30 for any covered preferred brand drug (The preferred brand drug list can be found on the PEEHIP Web site at www.rsa-al.gov.)
  - ◊ $50 for any covered non-preferred brand drug
- Participating pharmacies will file all claims for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP Express Scripts prescription drug plan.
- Members and covered dependents must use Curascripts for all specialty medications.
- The PEEHIP prescription drug plan includes Step Therapy and prior authorization for certain medications.

Non-Participating Pharmacy

- There are no benefits if you use a non-participating pharmacy in Alabama.
- Coverage outside Alabama: You will file the claim and be reimbursed at the Participating Pharmacy rate less the appropriate copay.

Out-of-State Coverage

- When you receive medical treatment outside Alabama, Medicare of that state is responsible for the payment of the claim. When you receive the Explanation of Medicare Benefits statement from that state, you must send Blue Cross a copy of the statement attached to a completed claim form in order for Blue Cross to consider the charges for payment. Always list your identification number on the claim form. Claim forms can be found on the PEEHIP Web site at www.rsa-al.gov.

Out-of-Country Coverage

- If you receive medical treatment outside the United States, Medicare may not make payment. In this situation, if the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross of Alabama.

Non-Participating Hospitals and Outpatient Facilities

- Currently there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are Blue Cross and Blue Shield participating providers. With your health plan benefits, you have the freedom to choose your health care provider.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don't have to worry about extra out-of-pocket expenses.

Excluded Services

- Coverage is not provided for nursing home costs, charges in excess of Medicare allowed charges, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids, and experimental procedures.

Viva Health HMO Plan

Description of Plan

The VIVA Health HMO Plan is a Hospital Medical plan option available to active employees and non-Medicare-eligible retirees who do not have Medicare-eligible dependents; in addition, the members must be living in the Viva Health service areas listed below. Additional guidelines for the VIVA Health HMO are:

- Members are not required to choose a personal physician from the VIVA Health directory.
- Members are not required to obtain a referral from a primary care physician to use a participating specialist.
- If members need services from a specialist, members can choose a specialist from the directory and make an appointment.
- A summary of the VIVA benefits is listed under the Comparison of Benefits on page 12.
- VIVA Health provides hospital medical and dental coverage and limited vision exam benefits.

Service Area

Coverage with VIVA Health Plan is available in the following areas:

Autauga	Chilton	Dekalb	Marion	Tuscaloosa
Baldwin	Clarke	Elmore	Mobile	Walker
Bibb	Cleburne	Fayette	Monroe	Washington
Blount	Conecuh	Greene	Montgomery	Winston
Bullock	Coosa	Hale	Perry	
Butler	Cullman	Jefferson	St. Clair	
Calhoun	Dale	Lawrence	Shelby	
Cherokee	Dallas	Madison	Talladega	

The VIVA HMO plan is not available to retired members who are Medicare eligible or to Medicare-eligible dependents.

PEEHIP SUPPLEMENTAL COVERAGE PLAN

(Administered by Blue Cross)

The supplemental hospital medical plan will:

- Provide secondary coverage to the members and covered dependent(s) when primary coverage is provided by another employer.
- Only active and non-Medicare eligible retiree members are eligible to enroll in the Supplemental Plan.
- There is no premium cost for the plan when the member uses the state allocation for the Supplemental Plan.
- The Supplemental Plan covers most deductibles, copayments, and coinsurance not covered by the primary plan.
- Participants may elect individual or family coverage.
- PEEHIP hospital medical plan exclusions and limitations continue to be imposed such as exclusions for dental coverage, cosmetic surgery, limitation on infertility treatment, etc.
- The Supplemental Plan does not cover or pick up any cost of services excluded by the primary plan because the plan is strictly a supplemental plan.
- The Supplemental Plan cannot be used as a supplement to Medicare, the PEEHIP hospital medical plan, or the State or Local Governmental plans administered by the State Employees' Insurance Board (SEIB).
- The Supplemental Plan only supplements your primary insurance plan by covering the copay, deductible and/or coinsurance of your primary insurance plan or the preferred/participating allowance, whichever is less.
- To be eligible for reimbursement under the PEEHIP Supplemental Coverage Plan, the primary insurance plan must have either 1) applied the eligible charges to the deductible, or 2) made primary payment for the services rendered.
- For inpatient mental health and substance abuse services, there is a maximum allowance of 30 total days per member per plan year.
- For outpatient mental health and substance abuse services, there is a maximum allowance of 10 visits per member per plan year.
- The PEEHIP Supplemental Coverage Plan does not pay for amounts in excess of the allowed amount for services rendered by a non-preferred provider, amounts in excess of the maximums provided under the primary insurance plan, any services denied by the primary insurance plan, or any penalties or sanctions imposed by the primary insurance plan.
- PEEHIP members cannot be enrolled in the PEEHIP hospital medical plan and the PEEHIP Supplemental Plan.

PEEHIP CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

(Administered by Blue Cross)

The following outlines PEEHIP's policies and procedures for determining when children of PEEHIP members qualify for CHIP:

- Member must be enrolled in the individual PEEHIP hospital medical plan.
- Member cannot carry family PEEHIP hospital medical plan and CHIP.
- Children must be under 19 years of age, eligible for the PEEHIP hospital medical plan coverage, and not in an institution.
- PEEHIP does not cover maternity benefits for dependent children in the PEEHIP hospital medical plan or in the CHIP plan. In addition.
- **PEEHIP does not cover dental or vision benefits in the PEEHIP hospital medical or in the CHIP plan.**
- Application is received during Open Enrollment or at the time of a qualifying event that would allow adding or deleting family coverage outside of Open Enrollment.
- Application must be accompanied by a complete, signed copy of the member's latest Federal Income Tax Return, along with copies of all pertinent W-2's and 1099's. If the member is married but filed a separate return, a copy of the spouse's latest Federal Income Tax Return, along with copies of all pertinent W-2's and 1099's, is also required.
- Application is prescreened for accuracy of the income records in relation to the income reported to the TRS for the member.
- Application is prescreened to determine if the child/children are covered by Medicaid. If the child/children are covered by Medicaid, they are not eligible for CHIP coverage.
- Family size is determined by the total number of persons who are exemptions on the Federal Tax Return.
- Income is determined as Total Income before any adjustment or deductions on the Federal Tax Return.
- The income range for qualifying for the CHIP plan is 100% to 200% of the current Federal Poverty Level per family size. The Federal Poverty Level by family size is updated annually in February. PEEHIP will update the ranges used each Open Enrollment with the most current ranges issued.
- If the applicant is determined to be under the income/family size qualification, the applicant will be notified of potential Medicaid eligibility.
- If the applicant is determined to be within the income/family size qualifications, the applicant's children under age 19 will be enrolled in CHIP.
- The yearly premium is $50 per child with a maximum of $150 yearly premium for three (3) or more children.
- If the application is determined to be over the income/family qualification, the applicant will be notified that he or she does not qualify for CHIP.

- Enrollment in the CHIP plan is only applicable for the year ending each September 30. **Members must re-enroll each Open Enrollment.**
- Coverage in the PEEHIP CHIP plan will terminate on the last day of the month in which any of the following events occur: covered child is no longer eligible as a dependent under CHIP, death of the covered child, nineteenth birthday of the covered child, notification to PEEHIP that covered child becomes covered by other health insurance, member enrolls in the family PEEHIP hospital medical or member terminates employment and, as a result, enrolls in the PEEHIP COBRA plan.

OPTIONAL PLANS (Administered by Southland National)

(Cancer, Dental, Hospital Indemnity, and Vision)

There are four Optional plans offered through PEEHIP. A synopsis of these plans is provided below. More detailed information will be provided to those who enroll in the plan(s). Claims administration is provided through the Southland National Insurance Company. All Optional plans must be retained for the entire insurance year, i.e. until September 30. New employees employed during the Open Enrollment period cannot enroll in the Optional plans on their date of employment and cancel the plans October 1 of that same year.

If a member is enrolled in more than one of the Optional plans, the contracts must be all family or all single plans. Members enrolled in family optional plans cannot change to single Optional plans outside of the Open Enrollment period unless all dependent(s) become ineligible due to age, death or divorce. Listed below are merely summaries of benefits for the Optional plans. Members should refer to the PEEHIP Member Handbook for detailed information and limitations.

Cancer Plan

- This plan covers cancer disease only.
- Benefits are provided regardless of other insurance.
- Benefits are paid directly to the insured unless assigned.
- Coverage provides $250 per day for the first 90 consecutive days of hospital confinement, $500 per day thereafter.
- Actual surgical charges are paid up to the amounts in the surgical schedule.
- The lifetime maximum benefit for radiation and chemotherapy coverage is $10,000. This benefit covers actual charges for cobalt therapy, x-ray therapy, or chemotherapy injections (excluding diagnostic tests).
- Benefits are also provided for Hospice care, anesthesia, blood and plasma, nursing services, attending physician, prosthetic devices, and ambulance trips.

Dental Plan

- This plan covers diagnostic and preventative services, as well as basic and major dental services.
- Diagnostic and preventative services are not subject to a deductible and are covered at 100% (based on Alabama reasonable and customary charges). These services include: oral examinations, teeth cleaning, fluoride applications for insured children up to age 19, space maintainers, x-rays, and emergency office visits.
- Routine cleaning visits are limited to two times per plan year.
- Basic and major services are covered at 80% for individual coverage and 60% for family coverage with a $25 deductible for family coverage (based on the Usual Customary Rates (UCR) for Alabama). These services include: fillings, general anesthetics, oral surgery not covered under a Group Medical Program, periodontics, endodontics, dentures, bridgework, and crowns.
- The family coverage deductible for basic and major services is applied per person, per plan year with a maximum of three (3) per family.
- All dental services are subject to a maximum of $1,250 per year for individual coverage and $1,000 per person per year for family coverage. Dental coverage does not cover pre-existing dentures or bridgework, nor does it provide orthodontia benefits.
- The dental coverage does not cover the replacement of natural teeth removed before a member's coverage is effective.
- This plan does not cover temporary partials, implants, or temporary crowns.
- The dental plan administered by Southland National also offers a money-saving network program known as DentaNet. Under the DentaNet program, members have the opportunity to use network dentists but still have the freedom to use any dentist.
- Dental benefits under this plan will always be paid secondary to other dental plans.

Hospital Indemnity Plan

- This plan provides a per-day benefit when the insured is confined to the hospital.
- The In-Hospital Benefit is $150 per day for individual coverage and $75 per day for family coverage.
- In-hospital benefits are limited to 365 days.
- Intensive care benefit is $300 per day for individual coverage; $150 per day for family coverage.
- Convalescent care benefit is $150 per day for individual coverage; $75 per day for family coverage.
- Convalescent care benefits are limited to a lifetime benefit of 90 days. This plan does not cover assisted living facilities.
- Cancer and maternity admissions are covered as any other illness.

- There is supplemental accident coverage for $1,000. The reimbursement for an accident(s) is limited to a maximum of $1,000 per contract year for each covered individual. There is no limit on the number of accident claims that can be filed per contract year.

Vision Care Plan

This plan provides coverage for:

- One examination in any 12-month period (actual charges up to $40)
- One new prescription or replacement prescription for lenses per plan year (up to $50 for single vision, $75 for bifocals, $100 for trifocals, and $125 for Lenticular)
- One new prescription or replacement of contacts per plan year (up to $100 for contact lenses)
- One new or replacement set of frames per plan year (up to $60)
- Either glasses or contacts, but not both in any plan year
- Disposable contact lenses
- Vision benefits under this plan will always be paid secondary to other vision plans.

Remember, this is only a summary of benefits. Members should refer to the appropriate benefit booklet for detailed information and limitations.

Coordination of Benefits

If an employee is enrolled in the dental and/or vision plans provided by PEEHIP and is also entitled to any other dental or vision coverage, the total amount that is payable under all plans will not be more than 100% of the covered expenses. In addition, PEEHIP will coordinate benefits with other dental and vision coverages. A member must correctly complete the Additional Group Health Insurance Coverage Information section of the Health Insurance and Optional Enrollment Application and update PEEHIP when changes are made.

Members and dependents are legally required to notify PEEHIP of other coverage. Also, employers must inform PEEHIP when other insurance coverage of any kind is provided to employees by their system. Claims incurred and filed on the PEEHIP dental and vision plans administered by Southland National are always paid secondary to other dental and vision plans.

Flexible Spending Accounts *(Administered by Blue Cross)*

The PEEHIP Flexible Spending Accounts program is available to all **active** members of PEEHIP. Retired members are not eligible to participate in any of the Flexible Spending Accounts. The PEEHIP Flexible Spending Accounts consist of the following three programs:

1. **Premium Conversion Plan** requires all active members to pay premiums for PEEHIP using pre-tax dollars. This plan is strictly a function of the payroll system in which the member no longer has to pay federal and state of Alabama income taxes on their health insurance premium.
2. **Dependent Care Flexible Spending Account** allows eligible active members the opportunity to pay dependent care expenses using pre-tax dollars.
3. **Health Care Flexible Spending Account** allows eligible employees to set aside tax-free money in an account to pay themselves back for eligible health care expenses incurred by them and their dependents.

The open enrollment deadline for the Flexible Spending Accounts is September 30, 2008, for an effective date of October 1, 2008. Members who are currently enrolled in a Flexible Spending Account through their employer are allowed to enroll in the PEEHIP spending accounts at the end of their employer's plan year. **All members currently enrolled in the PEEHIP Flexible Spending Accounts must re-enroll every year.** These programs do not automatically renew each year.

To enroll in the Flexible Spending Accounts, members must complete the Flexible Spending Account Enrollment Application located in the back of this packet and return the form to the PEEHIP office prior to October 1, 2008. Members can also enroll in the Flexible Spending Accounts by using the new and improved Member Online Services system at **www.rsa-al.gov**. More information is available at www.bcbsal.org/peehip1/preferredBlue/index.cfm.

Listed below are some of the eligible expenses that can be paid from your Flexible Benefits Account:

Health Care Flexible Spending Account

- Prescription drug co-pays as well as over-the-counter medications
- Physician co-pays
- Vision care including Lasik and Prelex surgery
- Hearing care
- Deductibles

- Orthodontia
- Coinsurance

Dependent Care Flexible Spending Account
- Licensed nursery school and day care facilities for children
- Child care in or outside your home
- Day care for an elderly or disabled dependent

To determine how much per year you want to contribute to your Flexible Spending Account(s), you should assess what your expenses were the year before and determine if these expenses will occur again and then add in any new expenses. Your annual contributions must be whole dollars. The maximum annual amount for the Dependent Care Account is $5,000 if single or married filing a joint return or $2,500 if married filing a separate return; and $5,000 for the Health Care Account. The funds are deducted from your pay before taxes are withheld and deposited into your account.

If your medical and/or dental insurance is with any PEEHIP medical or optional plan, your out-of-pocket expenses for medical and/or dental services will automatically apply to your Flexible Spending Account. If you have medical, dental or secondary coverage with another insurance plan, you will need to file a Request for Reimbursement form with appropriate documentation and provide documentation of what the other carrier paid.

The out-of-pocket money is reimbursed to you from your account. You may even elect to have it deposited directly into your checking or savings account. Amounts unused and unspent in the Health Care Flexible Spending Account as of September 30 can be used to pay for out-of-pocket medical expenses incurred during the 2 ½ month grace period ending December 15. Expenses for both the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year. If you do not use the money in your account from the previous plan year by the end of the grace period, you will lose it.

COMPARISON OF BENEFITS
EFFECTIVE OCTOBER 1, 2008 – SEPTEMBER 30, 2009
(Changes are in bold)

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	**VIVA Health Plan HMO*** (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Preventive Medical	$20 copayment then covered in full	$15 copayment then covered in full
Well Baby Care	$20 copayment per visit (6 visits 1st year; 1 visit/yr. thru age 6; one exam every 2 yrs ages 7 - 18)	$15 copayment then covered in full
Routine Immunizations	$20 copayment then covered in full	$15 copayment then covered in full
Office Care		
Physician's Care	$20 per visit	$15 per visit for primary care. $30 for specialty care. Referrals are no longer necessary.
Lab Procedure	$3 per test	Covered in full (after office visit copayment)
Maternity		
Physician's Care	Covered in full	$30 copayment (initial visit only) then covered in full
Inpatient	$100 hospital copayment	Covered in full after $200 copayment
Hospital Services	$100 copayment per admission	$200 copayment per admission
Outpatient Surgery	$75 copayment	$75 copayment, then covered in full
In-Hospital Care		
Surgeon	Covered in full	Covered in full
Physician Visits	Covered in full	Covered in full
Anesthesiologist	Covered in full	Covered in full
Emergency		

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	**VIVA Health Plan HMO*** (In approved areas only) (Available for Active and Non-Medicare Members Only.)
In Area/Out of Area Emergency Room	$25 per visit, accident within 72 hours covered 100%	$50 emergency room visit for facility, waived if admitted within 24 hours; Physician's charges covered at 100%.
Mental Health and Substance Abuse		
Inpatient	Copayments: Days 1-9 $0, days 10-14 $15, days 15-19 $20, days 20-24 $25, days 25-30 $30. Maximum of 30 days per member per fiscal year at approved facilities. Limit of one substance abuse admission per year and two admissions per lifetime.	Mental Health covered at 50%. Maximum benefit for mental health is 30-day combined maximum for mental health/substance abuse per calendar year. Substance abuse is limited to detox only. Maximum of 3 days/occurrence with 50% coverage.
Outpatient	$10 copayment for up to 20 outpatient visits at approved facilities.	100% coverage after $50 copayment per visit. Subject to 20-visit combined maximum for mental health/substance abuse per calendar year.
Prescription Drugs	(Administered by Express Scripts.) Generic - $5 copayment Formulary (preferred brand name) drugs $30 copayment. Non-formulary (non-preferred brand name) drugs $50 copayment. Approved Maintenance drugs covered for 90-day supply. First fill for a new maintenance drug will be a 30-day supply. **Certain medications have quantity level limits to comply with the FDA guidelines and to ensure drug safety for our members.** **Certain medications are subject to Step Therapy.** **Prior authorizations are required before covered members can receive certain medications.** No benefits available when a non-participating pharmacy in the State of Alabama is used. Out-of-State non-participating pharmacies are paid at the participating pharmacy rate. Members pay difference in cost plus appropriate copayments. Pharmacists must dispense generic drug unless physician indicates in longhand writing on the prescription "Do Not Substitute", "Medically Necessary", or "Dispense as Written."	Generic - $12 copayment Brand Name - *$25 preferred brand (formulary) *$45 non-preferred (non-formulary) *When an appropriate grade generic is available and brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs. 50% coverage for Mental Health drugs. 90% coverage for self-administered injectibles, bio-technical and biological drugs. $3,000 maximum payment in drug costs, per plan year, per person. Participating pharmacies only. Mail Order pharmacy is available. Oral contraceptives are covered subject to the appropriate copayment.

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	**VIVA Health Plan HMO*** (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Other Services		
Out-of-State Coverage for Non-PPO Provider	Major Medical benefits apply - payable at 80% UCR after $100 yearly deductible	Only Emergency and Urgent Care Services and Prescription Benefits available
Out-of-State Coverage for PPO Provider	$20 copayment per visit. Members must use providers participating in the Blue Cross plan of that State.	N/A
Vision Examinations	Not Covered	Covered in full once each 12 months after a $30 copayment with participating provider.
Dental	Not Covered	The Dental Plan allows you to seek treatment from any licensed dentist. The plan reimburses a percentage of eligible expenses based on usual, customary and reasonable (UCR) fees. **Beginning October 1, 2008, the VIVA dental benefits will be administered by Delta Dental.** Type I – Preventive & Diagnostic – 100% of UCR Type II – Basic Services – 50% of UCR Type III – Major Services** - 25% of UCR Deductible (applies to Basic & Major Services) - $50 per person/$150 per family Calendar Year Max - $500 **12-month Waiting Period applies to Major Services
Spinal Service & Chiropractic Services	Participating Chiropractor – Covered at 80% of the allowed amount with no deductible. After 12 visits in a calendar year, services are subject to precertification. Non-participating Chiropractor- Covered under major medical at 80% of allowed amount. Member will owe 20% coinsurance, major medical deductible and charges over allowed amount.	Limited to 10 visits per calendar year. $30 copayment per visit.
Infertility Services	Benefits for medically necessary infertility services are available for artificial insemination and related services. Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP per member contract. Members will pay 100% of the medications after the $2,500 lifetime maximum is reached. Benefits are not provided for Assisted Reproductive Technology (ART).	Coverage for infertility services is limited to initial consultation and one counseling session only. Testing is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member's lifetime). Treatment for infertility is not a Covered Service.

** VIVA Health Plan HMO: No referral from a primary care physician (PCP) is required. Members must select a PCP and use participating physicians and specialists. Members must use participating hospitals.*

Creditable Coverage Notice About Your Prescription Drug Coverage and Medicare

This information is about your current prescription drug coverage with PEEHIP and prescription drug coverage under Part D of Medicare for people with Medicare. It also explains where to find more information to help you make decisions about your prescription drug coverage.

- The Public Education Employees' Health Insurance Plan (PEEHIP) has elected to continue providing prescription drug benefits even when members are eligible for Medicare Part D benefits. However, members cannot enroll in Medicare Part D and continue with PEEHIP prescription drug coverage.

- The prescription drug coverage offered by PEEHIP is expected to pay out as much as the standard Medicare prescription drug coverage and, therefore, the PEEHIP prescription drug coverage is considered "creditable coverage" as defined by Medicare.

- "Low-income" individuals may be eligible for prescription drug subsidies. Therefore, these individuals may be better off applying for a subsidy and Medicare part D (two separate steps).

- Individuals dropping or losing their PEEHIP coverage must enroll in Medicare Part D within 60 days or they will be subject to a higher premium.

If you do decide to enroll in a Medicare prescription drug plan and drop your PEEHIP prescription drug coverage, be aware that you will lose your PEEHIP drug coverage and will not be able to get this coverage back until you drop the Medicare Part D coverage. Keep in mind that you will not be able to take advantage of coverage under both the PEEHIP prescription drug program and through Medicare Part D.

Because the PEEHIP prescription drug coverage is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later without a late enrollment penalty. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 and December 31.

Compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In most cases, PEEHIP will continue to be your best choice to maximize your benefits.

An exception may apply to certain "low-income" individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Part D (two separate steps). Individuals who have incomes below 150 percent of the Federal Poverty Level and assets of no more than $10,000 per individual or $20,000 per couple (not including homes, cars, household furnishings and possessions) may be eligible for the prescription drug subsidies. The Social Security Administration (SSA) has developed an application form and process to determine eligibility. If you feel you may qualify, go to the SSA Web page at **www.socialsecurity.gov** and click Medicare Prescription Drug Plan. Also, you may call or visit your local SSA office for more details; the national toll-free number is **800-772-1213**.

PEEHIP members who drop or lose their coverage with PEEHIP and do not enroll in Medicare prescription drug coverage after their current coverage ends, may pay more to enroll in Medicare Part D later. Individuals having a 60 day or longer break in prescription drug coverage that is at least as good as Medicare's prescription drug coverage will be subject to at least 1% per month premium increase for every month after May 15, 2006, that they did not have prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. This higher premium will continue as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Public Education Employees' Health Insurance Board has elected to exempt the **Public Education Employees' Health Insurance Program** from the following requirement:

> Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The exemption from this federal requirement has been in effect since October 1, 2005. The election has been renewed every subsequent plan year.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

For more information regarding this notice, please contact PEEHIP.

FORMS

Mail forms to: Public Education Employees' Health Insurance Plan
P.O. Box 302150
Montgomery, AL 36130-2150

A self-addressed envelope is included in this packet to return forms to PEEHIP. Do not send any forms to Blue Cross Blue Shield, VIVA, or Southland National. When completing these forms, make sure the name of the subscriber and dependents is the same as the name on their Social Security card. Forms may also be downloaded from our Web site at **www.rsa-al.gov**.

Health Insurance and Optional Enrollment Application – This form is to be used if you are: a **new** employee; an active or retired member who is **not** enrolled in any coverage; or an active or retired member who wants to **enroll** in one or more Optional Coverage Plans that you are not enrolled in, or are not enrolled in a Hospital Medical Plan and want to enroll. Any **changes** to existing coverages are to be made on the Health Insurance and Optional Status Change form.

Health Insurance and Optional Status Change – This form is to be used if you are an active or retired member currently enrolled in PEEHIP and you want to make changes to your existing coverage, and/or to certify or change your or your spouse's tobacco status. Examples: change from single to family coverage or vice-versa; cancel coverage; change your Hospital Medical Plan; add or cancel a dependent to or from family coverage. **Important:** You must provide the Requested Effective Date or the form will be returned to you for completion.

Flexible Spending Account Enrollment Application – This form is to be used if you are an **active** member and you wish to enroll or re-enroll in the Health Care and/or Dependent Care Flexible Spending Accounts. **Important:** You must re-enroll in these programs **every year** as these programs will **not** automatically renew each year without a new enrollment application. The **Health Care Account** allows members to pay for non-covered health care expenses with pre-tax dollars. The **Dependent Care Account** allows members to pay for dependent care expenses with pre-tax dollars.

Flexible Spending Account Status Change – This form is to be used if you are an **active** member and you enrolled or re-enrolled in a Flexible Spending Account(s) during Open Enrollment and subsequently wish to make a **change** to the annual contribution amount of your Flexible Spending Account(s) **before** the end of Open Enrollment or during the year if you have a qualifying life event.

Federal Poverty Level Assistance (FPL) Application and Children's Health Insurance Plan (CHIP) Application – This form is to be used by eligible active and retired members to apply for the FPL premium discount and/or to enroll or re-enroll in the PEEHIP CHIP plan. **Members must re-enroll in these programs every year.** These programs will not automatically renew each year without a new application.

Important for New Employees
The Health Insurance and Optional Enrollment Application must be completed within 30 days of the member's employment date.

ONLINE FORMS

PEEHIP has a new and improved Member Online Services system that is fast, free, secure and accurate! Click on the **Member Online Services** link from the RSA Web site at www.rsa-al.gov to access the new online system. All you need is a User ID and Password. If you don't already have these, registering for an account is easy! The link above will guide you through the necessary steps to set up your account to obtain a User ID and Password.

PEEHIP Members Can Do The Following Online:

- View Current Coverages
- View and/or Update your Contact Information
- Enroll, Change or Cancel your Hospital Medical Plan
- Enroll, Change or Cancel your Optional Coverage Plans (Cancer, Dental, Indemnity & Vision)
- Add, Update or Cancel your Other (non-PEEHIP) Group Insurance Coverage Information
- Enroll or Re-enroll in Flexible Spending Accounts
- Add or Update your Medicare Information
- Add or Update Retiree Employer Information
- Combine or Uncombine Allocations with your Spouse
- Update your Student Dependent Status
- Update your and/or your Spouse's Tobacco Usage Status
- Add Dependent(s) to Coverage
- Cancel Dependent(s) from Coverage

Enroll (05/08)
0J

HEALTH INSURANCE AND OPTIONAL ENROLLMENT APPLICATION

Check One:
☐ Active Member
☐ Retired Member

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
(334) 832-4140 or 1-800-214-2158
Web site: www.rsa-al.gov

PEEHIP

This form is to be used to enroll in new coverages.
Any other changes are to be made on the Health Insurance and Optional Status Change Form.
In lieu of completing and mailing this form, you can make your changes online using the Web site above.
Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Sex
_____/_____/_____	_____-_____-_____	_____-_____-_____	☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer/School System	Date of Employment
	_____/_____/_____

Have you or your spouse used tobacco products within the last 12 months?*
Member: ☐ Yes ☐ No
Spouse: ☐ Yes ☐ No

This information is required for enrollment.

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office.

Basic Hospital/Medical
(*Select only one of the three plans*)

Note: *PEEHIP plans are administered by Blue Cross and Blue Shield of AL*

Coverage Type:
☐ PEEHIP Hospital/Medical
☐ PEEHIP Hosp/Med Supplemental**(*see Group Health on back*)
This plan is not a Medicare supplement & differs from Optional Plans.
☐ VIVA Health Plan (HMO)

☐ Single or ☐ Family

Requested Effective Date _____/_____/_____ ***(required)***

Primary Care Physician *(HMO only)*

Optional Coverage(s)
(*administered by Southland National*)

Note: *Optional plans must be all Single or all Family*

Coverage Type(s):
☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision

☐ Single or ☐ Family

Requested Effective Date _____/_____/_____ ***(required)***

Optional coverage(s) must be retained for one year until the following October 1. The PEEHIP office will not automatically cancel any coverage(s). All cancellations must be indicated on the Health Insurance Status Change form.

Dependent Information *(only required for family coverage)*

Note: *Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card.*
Enrollments cannot be processed without the appropriate documentation as explained in the Member Handbook for any starred (*) items.

Name of Dependent *(First, MI, Last)*	Social Security Number	Date of Birth	Relationship to Subscriber	Sex	If over 19:
			☐ Husband ☐ Wife ☐ Common-Law*	☐ M ☐ F	
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*

Student Verification *(only necessary to complete for dependent children between the ages of 19 and 25)*

If full-time student, list dependent's first name and university, college, or accredited vocational school.

Name	School	Term Attending	Hours Enrolled
Name	School	Term Attending	Hours Enrolled

Combining of Allocations

Allocations can only be combined at certain times and only if your spouse is independently eligible for PEEHIP.

I wish to ☐ transfer ☐ receive the state insurance allocation ☐ to ☐ from my spouse.

Spouse's Social Security Number: _____-_____-_____ Effective Date of Combining Allocations: _____/_____/_____

Additional (Non-PEEHIP) Group Health Insurance Coverage Information**

This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder

Policy Effective Date	Type of Coverage
_____/_____/_____	☐ Single ☐ Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

**If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

Retiree Employer Information

The following fields must be completed by PEEHIP members who retire after September 30, 2005.

Pursuant to Act 2004-649, if you retire after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? ☐ Yes ☐ No If yes, please complete the employer information below.

Employer	Date of Employment
	_____/_____/_____

Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? ☐ Yes ☐ No

If yes, will your employer pay at least 50% of the cost of single health insurance coverage? ☐ Yes ☐ No

Name of Insurance Company	Policy Effective Date	Type of Coverage
	_____/_____/_____	☐ Single ☐ Family

PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature _____ Date Signed _____/_____/_____

Please mail the completed form to the address located on the front of this form.

Change (05/08)
50

Check One:
☐ Active Member
☐ Retired Member

HEALTH INSURANCE AND OPTIONAL STATUS CHANGE

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
(334) 832-4140 or 1-800-214-2158
Web site: www.rsa-al.gov

PEEHIP

This form is to be used to make changes to your existing insurance coverages and to certify or change your tobacco status.
In lieu of completing and mailing this form, you can make your changes online using the Web site above.
Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on Social Security card. ***All address changes must be made on the Retirement Systems of Alabama Address Change forms.***

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Date of Birth	Daytime Phone	Marital Status
____/____/____	_____-_____-_____	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Have you or your spouse used tobacco products within the last 12 months?* Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

This information is required for enrollment.

Please complete the following fields if you have changed your name or changed employers.

Previous Full Name *(First, MI, Last)* / Previous School System	New Full Name *(First, MI, Last)* / New School System	Date of Employment Transfer
		____/____/____

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office. The PEEHIP office will not automatically cancel any coverage(s). ***All cancellations must be indicated on the Health Insurance Status Change form.***

Coverage Type: (Only check boxes requiring a change)	**PEEHIP Hosp/Med**	**PEEHIP Supplemental**	**VIVA HMO**	*(Optional plans must be all Single or all Family)* **Cancer**	**Dental**	**Indemnity**	**Vision**
Change from Single to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed below to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Single** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed below from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date ____/____/____ *(Date must be included or form will be returned)*
Note: You will be billed for prorata premiums or for premiums that are not deducted.

Reason for Status Change(s)

Changes cannot be processed without the appropriate documentation as explained in the member handbook for starred (*) items. ***Active members must have an IRS qualifying event to cancel their hospital medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed.***

☐ Adoption of a child* *(need adoption papers)*
☐ Birth of a child* *(need birth certificate)*
☐ Death of spouse/dependent* *(need death certificate)*
☐ Dependent age 19 or older changing student status*
☐ Dependent loss of coverage* *(need proof of loss of coverage)*
☐ Divorce/Annulment* *(need divorce decree)*

Date change occurred ***(Required)*** ____/____/____

☐ Legal custody of a child* *(need custody papers)*
☐ Marriage* *(need marriage certificate)*
☐ Marriage of dependent child
☐ Open Enrollment
☐ Termination of spouse/dependent employment*
☐ Commencement of spouse/dependent employment*
☐ Medicare/Medicaid entitlement* *(need copy of card)*

Dependent Information *(only required for family coverage)*

Note: *Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card.*
Enrollments cannot be processed without the appropriate documentation as explained in the Member Handbook for any starred (*) items.

Name of Dependent *(First, MI, Last)*	**Social Security Number**	**Date of Birth**	**Relationship to Subscriber**	**Sex**	**If over 19:**
			☐ Husband ☐ Wife ☐ Common-Law*	☐ M ☐ F	
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ______	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*

Student Verification *(only necessary to complete for dependent children between the ages of 19 and 25)*

If full-time student, list dependent's first name and university, college, or accredited vocational school.

Name	School	Term Attending	Hours Enrolled
Name	School	Term Attending	Hours Enrolled

Combining of Allocations

Allocations can only be combined at certain times and only if your spouse is independently eligible for PEEHIP.

I wish to ☐ transfer ☐ receive the state insurance allocation ☐ to ☐ from my spouse.

Spouse's Social Security Number: ____-____-____ | Effective Date of Combining Allocations: ____/____/____

Additional (Non-PEEHIP) Group Health Insurance Coverage Information

This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder

Policy Effective Date	Type of Coverage
____/____/____	☐ Single ☐ Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:____/____/____ ☐ Part B-Effective:____/____/____ ☐ Part D*-Effective:____/____/____

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:____/____/____ ☐ Part B-Effective:____/____/____ ☐ Part D*-Effective:____/____/____

**If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

Retiree Employer Information

The following fields must be completed by PEEHIP members who retire after September 30, 2005.

Pursuant to Act 2004-649, if you retire after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? ☐ Yes ☐ No | If yes, please complete the employer information below.

Employer	Date of Employment
	____/____/____

Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? ☐ Yes ☐ No

If yes, will your employer pay at least 50% of the cost of single health insurance coverage? ☐ Yes ☐ No

Name of Insurance Company	Policy Effective Date	Type of Coverage
	____/____/____	☐ Single ☐ Family

PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature _____ Date Signed ____/____/____

Please mail the completed form to the address located on the front of this form.

FSA (05/08)
2H

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
(334) 832-4140 or 1-800-214-2158
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
___-___-___			

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	
___/___/___	___-___-___	___-___-___	

Healthcare Flexible Spending Account Information

I wish to enroll in the Health Care Flexible Spending Account. ☐Yes ☐No

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- Do not include health insurance premiums in your annual election amount.
- The maximum annual amount cannot exceed $5,000.

Dependent Care Flexible Spending Account Information

I wish to enroll in the Dependent Care Flexible Spending Account. ☐Yes ☐No

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- Do not enroll in the Dependent Care Flexible Spending Account for reimbursement of out-of-pocket medical costs for dependents. You must use the Healthcare Flexible Spending Account instead.
- The maximum annual amount cannot exceed:
  - $5,000 if single or married filing a joint return, or
  - $2,500 if married filing a separate return.
- Remember to factor in the summer childcare costs.

PEEHIP Subscriber Certification

I understand that:

- I cannot change or revoke any of my elections on this compensation redirection agreement at any time during the plan year (Oct. 1 – Sep. 30) unless I have a qualifying change in status.
- During the Annual Open Enrollment Period, I will be given the opportunity to enroll in the plan for the upcoming plan year (Oct. 1 – Sep. 30). I must enroll each year during the Open Enrollment period since participation in the plan for subsequent years is not automatic, even if I want to contribute the same amount as the previous year.
- Amounts unused and unspent in the Healthcare Flexible Spending Account as of September 30 can be used to pay for out-of-pocket medical expenses incurred during the 2 ½ month grace period ending December 15.
- Expenses for both the Healthcare Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year.

I hereby certify that I have completely read and fully understand the terms and conditions of the Flexible Spending Account and all information furnished is true and complete.

Employee Signature _____ Date Signed ___/___/___

FSA Change (05/08)
2I

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
(334) 832-4140 or 1-800-214-2158
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone
_____/_____/_____	_____-_____-_____	_____-_____-_____

Reason for Status Change

I certify that I have incurred the following change in status:

- ☐ Marriage
- ☐ Marriage of dependent
- ☐ Birth of a child
- ☐ Adoption of a child
- ☐ Legal custody of a child
- ☐ Divorce/annulment
- ☐ Death of spouse/dependent
- ☐ Dependent loss of coverage
- ☐ Significant change in medical benefits or premiums
- ☐ Termination of spouse/dependent employment
- ☐ Commencement of spouse/dependent employment
- ☐ Taking leave under the Family and Medical Leave Act
- ☐ Medicare/Medicaid entitlement
- ☐ Unpaid Leave of Absence
- ☐ Short plan year

Date qualifying event occurred *(Required)* _____/_____/_____

Note: *PEEHIP must be notified within 45 days of the occurrence of the qualifying event.*

Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $5,000.

☐ Stop Payroll Deductions

Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $5,000 if single or married filing a joint return, $2,500 if married filing separate returns.

☐ Stop Payroll Deductions

PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature _____ Date Signed _____/_____/_____

FPL & CHIP (05/08)
2G

FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION (FPL)
AND
CHILDREN'S HEALTH INSURANCE PROGRAM APPLICATION (CHIP)

I'm applying for:
- ☐ FPL
- ☐ CHIP
- ☐ FPL and CHIP

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
(334) 832-4140 or 1-800-214-2158
Web site: www.rsa-al.gov

This form is to be used to apply for the Federal Poverty Level Premium Assistance and/or to apply/enroll in PEEHIP CHIP.

PEEHIP Subscriber Information - *Required*

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Home Phone	Work Phone	Date Received *(For internal use only)*
_____-_____-_____	_____-_____-_____	_____/_____/_____

Children's Health Insurance Plan Applicants Only

Note: *Social Security Number is required for all household members. Name must be entered as it appears on the Social Security card.*

Is any child covered under Medicaid? ☐ Yes ☐ No | If yes, which child(ren)?

Names of Household Members *Line A – PEEHIP Subscriber* *Line B – Subscriber's Spouse* *Lines C-F – Children under 19 years of age living in your home*	Social Security Number	Date of Birth	Age	Sex	Relationship to PEEHIP Subscriber
A.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	Self
B.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	Spouse
C.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
D.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
E.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
F.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	

Requested Effective Date _____/_____/_____ ***(required)***

If you do not qualify for CHIP, do you wish to enroll children under the PEEHIP Hospital/Medical Plan? ☐ Yes ☐ No

Do any of these dependent children have other health insurance coverage? ☐ Yes ☐ No

If yes, which child(ren)? *(A copy of the insurance card is required.)*

Instructions

1. A **signed** copy of your prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's must be attached. If you were married and did not file a joint return, you must also file a copy of your spouse's prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's in order for this application to be processed.
2. You must reapply for this assistance every year during Open Enrollment.
3. Any Federal Poverty Level assistance application received and/or postmarked after the close of Open Enrollment (September 1) will be effective for the first day of the second month after the receipt and approval of the application.

PEEHIP Subscriber Certification - *Required*

I declare that the above information and the accompanying tax returns and supporting 1099's and W-2's are true, complete, and accurate. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also understand that if any statements or accompanying tax returns and supporting 1099's and W-2's are found to be incorrect, incomplete, false, or misleading, I will be required to repay all discounts plus interest. This certification authorizes the Alabama Department of Revenue (or corresponding agency of the state of member's residency) to release to PEEHIP all of the member's and his/her spouse's tax returns in the agency's records for the current and prior tax year.

Employee Signature _____ Date Signed _____/_____/_____

Spouse Signature _____ Date Signed _____/_____/_____

Please mail the completed form to the address located on the top of this form.
See reverse for FPL discounts and levels.

FEDERAL POVERTY LEVEL ASSISTANCE PROGRAM (FPL)

PEEHIP provides premium assistance to PEEHIP members with a combined family income of less than or equal to 200% of the Federal Poverty Level (FPL) as defined by Federal Law. To qualify for the FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Certification of Income Level will be effective for the plan year only, and re-certification will be required annually during Open Enrollment. The premium reduction does not automatically renew each year. The premium reduction will apply only to the hospital medical premium or HMO premium.

Federal Poverty Level Premium Discount:

Over 200% of the FPL	member pays 100% of the member contribution	
equal to or less than 200% but more than 175% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 175% but more than 150% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 150% but more than 125% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 125% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2008 Federal Poverty Levels (FPL)

Family Size	100% of FPL	125% of FPL	150% of FPL	175% of FPL	200% of FPL
1 member	$10,400	$13,000	$15,600	$18,200	$20,800
2 members	$14,000	$17,500	$21,000	$24,500	$28,000
3 members	$17,600	$22,000	$26,400	$30,800	$35,200
4 members	$21,200	$26,500	$31,800	$37,100	$42,400
5 members	$24,800	$31,000	$37,200	$43,400	$49,600
6 members	$28,400	$35,500	$42,600	$49,700	$56,800
7 members	$32,000	$40,000	$48,000	$56,000	$64,000
8 members	$35,600	$44,500	$53,400	$62,300	$71,200
For each additional person, add	$3,600	$4,500	$5,400	$6,300	$7,200